

# Making sense of “excited delirium” in cases of death after police contact.

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## ***Making sense of 'excited delirium' in cases of death after police contact.***

### ***Abstract***

The term 'excited delirium' has been used by coroners' courts and police regulators in England and Wales to classify some cases of death after police contact. It is suggested that this term explains the extreme drug toxicity that gives individuals incredible strength and resistance to pain. This is despite excited delirium not being recognised as a condition by a number of healthcare organisations world-wide. Verdicts recorded by juries after deaths after police contact in coroners' courts in England and Wales in the period 2009-15 are analysed in addition to a review of extant literature on policing and excited delirium. The paper argues that although excited delirium is of uncertain aetiology and typically exists within a constellation of symptoms, it might still have utility in enabling police to identify and safely deal with individuals in crisis situations.

Key words: death after police contact, excited delirium, police accountability, coroners' courts

### ***Introduction***

Deaths after police contact (DAPC) have become increasingly contentious as they symbolise problems in the nexus between police and society related to legitimacy and accountability (Baker, 2016a, Savage, 2008). Cases such as Eric Garner<sup>1</sup> and Michael Brown<sup>2</sup> in the US, and Mark Duggan<sup>3</sup> and Ian Tomlinson<sup>4</sup> in the UK have come to epitomise the sometimes fractious nature of police interactions with society that often touch upon a perceived excessive use of force, particularly in relation to interactions with members of Black and Minority Ethnic (BME) communities (Hirschfield and Simon, 2010). Similarly, the use of police force against individuals with mental health issues has recently been acknowledged by a number of major policy reviews in England and Wales (IPCC, 2016, HMIC, 2013, Adebawale, 2013). Individuals who have issues with substance use and/or dependency have also been identified as being proportionally more likely to be subject to the police use of force and consequently die in custody as a result (Baker, 2016a, IPCC 2016, Hannan *et al.* 2010, Best *et al.* 2004). The issues of deaths in relation to BME communities, mental health issues, and substance use can be seen throughout the empirical evidence considered in this paper.

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<sup>1</sup> Died after being restrained in a choke hold by police officers on Staten Island in 2014. His family were offered \$5.9M in damages from the city of New York (Goodman, 2015).

<sup>2</sup> Died after being shot by a police officer in Ferguson, Missouri in 2014. His death caused widespread disorder and rioting in the Ferguson area (USA Today, 2014).

<sup>3</sup> Shot dead by a police officer in London in 2011. Widely believed to have precipitated the London riots that followed (Guardian/LSE, 2012).

<sup>4</sup> Died after being struck with a police baton and pushed to the ground in London by a police officer during the London G20 protests in 2009. Determined to have been 'unlawfully killed' by a coroner's court jury in 2011 (Greer and McLaughlin, 2012).

The condition known as excited delirium (ED)<sup>5</sup> appears to represent a juxtaposition of BME groups, mental health issues and substance use. In the US and Canada, ED is commonly identified with the use of Tasers by police officers (Wozniak, 2016). The available literature on ED in relation to police interactions comes principally from the US, but also from Canada. Whilst there is debate in the US literature as to whether ED exists as a 'condition' or cause of death, the Canadian literature is sceptical about its existence and thus its relevance as a cause of death after police interaction (see, for example Razack, 2015, Anaïs, 2014, Brodeur, 2010). This paper investigates ED using empirical evidence in cases of DAPC in England and Wales during the period 2009-2015.

It does this by using a documentary dataset of twelve narrative verdicts recorded in coroners' courts in the period 2009-2015 where ED is noted by juries as being a contributory factor in the death. Coroners' courts typically investigate cases of DAPC in England and Wales using a public inquest conducted before a jury (Matthews, 2011, Dorries, 2004). Juries increasingly record narrative verdicts<sup>6</sup> in these cases. These verdicts were developed in reaction to obligations imposed by Article 2 of the European Convention on Human Rights (ECHR) (Baker, 2016b). Narrative verdicts enable juries to record whatever contributory factors they deem relevant in recording the circumstances whereby individuals meet their deaths. They are used as an alternative to the more typically used 'short form' verdicts<sup>7</sup>. Narrative verdicts enable a significant amount of detail to be recorded by juries in contentious cases, partly as a way of noting concerns and consequently as a way of identifying issues for potential changes to policy or practice to prevent future deaths (Baker, 2016a, Matthews, 2014). The coroner's inquest is a fact-finding inquisitorial exercise as distinct to a blame-finding adversarial contest (Shaw and Coles, 2007, Levine, 1999). Whilst inquests might produce findings that are critical of individuals or institutions, they may not ascribe blame (Thomas *et al.* 2008). Inquests have manifold purposes, in cases of DAPC the need to learn lessons to prevent future deaths might be seen as being particularly relevant (Spray *et al.* 2012, Coles and Shaw, 2012).

Deaths after police contact are characterised by multiple causalities, leading them to be open to contestation as to how and why the individual died in the manner they did (Hannan *et al.* 2010, IAP 2010, Fulton, 2008). Those who die in such cases are disproportionately people who have mental health issues, are from BME communities, and/or be substance users (Baker, 2016a, Hannan *et al.* 2010, Coles and Shaw, 2012, Best *et al.* 2004). The use of force also tends to be a factor in such

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<sup>5</sup> Sometimes referred to as 'ExDS' (Excited Delirium Syndrome). See, for example Vilke *et al.* 2012, Storey, 2012.

<sup>6</sup> Termed determinations, or conclusions since July 2013 after direction from the Chief Coroner of England and Wales (Chief Coroner, 2014). Matthews (2014) notes that the media still tend to report them as 'verdicts'.

<sup>7</sup> There is insufficient space here to list all short form verdicts, but common examples are 'open', 'suicide', and 'death by misadventure' (Luce, 2003).

deaths, and in England and Wales this typically manifests itself as the use of physical restraint by police officers (IPCC, 2016). Cases of DAPC, then, tend to be contentious due the disproportionately high number of people who die from a combination of the factors noted above (Razack, 2015, Anaïs, 2014). It might not be surprising, therefore, to note that when ED is mooted as a cause of death, this is qualified by its presence within a constellation of symptoms (RCEM, 2016, Hall *et al.* 2013, Storey, 2012, Vilke *et al.* 2012, IAP 2010) underlining equivocal causality in cases of DAPC.

When police are called to incidents where the individual is exhibiting ED they are likely to encounter symptoms that include: 'bizarre, violent, and agitated behaviour...incoherent speech, hyperactivity; extreme endurance and unusual strength' (Wetli, 2006: 110-111); added to this potent mix are intense paranoia and an increased propensity to violence (Samuel *et al.* 2009). Individuals with ED are often hyperthermic (Hall *et al.* 2013, Kutcher *et al.* 2009) and have a tendency to rapidly go from being extremely agitated to calm (Wetli, 2006). The causes of ED are typically ascribed to drug toxicity, particularly cocaine and metamphetamine (Samuel *et al.* 2009, Wetli, 2006); but also nicotine (Kodikara *et al.* 2012); alcohol, marijuana, PCP, antidepressants, antipsychotics, and epileptic medication (Storey, 2012). However, ED can also be manifest without drugs, for example with certain psychiatric conditions (Marsh *et al.* 2009). It is, though, also important to note that not all individuals with ED die, nor do all those who die do so in police custody (see, for example Kutcher *et al.* 2009, Marsh *et al.* 2009). Wetli (2006: 101) estimates that approximately 10% of ED cases result in death to the individual. Vilke *et al.* (2012: 8) note that ED is now considered to be more of a 'syndrome' than a 'disease', a point acknowledged by a task force set up by the American College of Emergency Physicians (ACEP) in 2008 that found it to be: 'a real syndrome of uncertain etiology' (cited in Storey, 2012: 645).

Thus ED is marked by a wide variety of possible symptoms, causes, and contested definitions. It can relate to contentious police interactions with individuals of BME origin; with mental health and/or substance issues, and also relate to the use of force (Anaïs 2014, Storey 2012, Brodeur 2010). Small wonder that Wetli (2006: 99) cites a New York chief police officer stating that ED accounts for 1% of their cases but 99% of their headaches. The public expect police to provide a rapid response to emergency calls (Reiner 2010, Waddington, 1999) but in these cases police face a dilemma without cognisance of the consequences: the possibility of death or injury if individuals are not restrained, and the possibility of sudden death if they are restrained (Wetli, 2006). This paper uses data from coronial jury narratives to examine the way in which ED is recorded as being a contributory factor in the deaths of citizens. It examines what this might say about the utility of ED as a condition, or within a constellation of symptoms, that could enable lessons to be learned to prevent future deaths when police encounter citizens in crisis situations.

### ***Definitional ambiguities***

The term ED was coined by Wetli and Fishbain (1985) but its roots lie in the mid-nineteenth century as a psychiatric form of mania or delirium, originally known as ‘Bell’s mania’ (Vilke *et al.* 2012, Storey, 2012). Since then, it has acquired a number of labels. Within the dataset used in this paper there are also examples of coronial juries recording the terms ‘Acute Behavioural Disorder’, ‘Acute Psychotic Illness’, and ‘Amphetamine Induced Delirium’. This chimes with literature on the condition which identifies in excess of ten different labels for the phenomenon (Samuel *et al.* 2009). Examples noted by Wetli (2006: 102) include ‘acute exhaustive mania’, ‘agitated delirium’ (also noted by Menaker *et al.* 2009), and ‘acute excited states’ (also noted by Samuel *et al.* 2009). ‘Acute Behavioural Disorder’ is used in conjunction with ‘excited delirium’ by a 2016 policy document by the Royal College of Emergency Medicine (RCEM) in the UK which provides guidelines for its management by police and medical services (RCEM 2016). In a report into ED commissioned by the government of Nova Scotia, Kutcher *et al.* (2009: ii) overtly eschew the term ‘excited delirium’, instead preferring ‘autonomic hyperarousal state’. In the US, a National Institute of Justice (NIJ) review into ED defined it as ‘an altered mental state with impaired cognition and perception, and severe psycho-motor agitation’ (NIJ, 2011: 37). Moreover, there is significant debate within the medical and scientific community about whether ED is a recognised medical condition (Anaïs, 2014). It is not recognised by the American Medical Association or the World Health Organisation (Wozniak, 2016, Samuel *et al.* 2009). It is, however, recognised by the American National Association of Medical Examiners and the American College of Emergency Physicians (Hall *et al.* 2013, Storey, 2012, Vilke *et al.* 2012). Whilst major medical agencies do not acknowledge it, organisations that deal with emergency cases such as emergency physicians, or mortalities, such as medical examiners (ME) do (NIJ 2011).

In the UK, whilst ED is not recognised by the Department of Health (DoH) it is noted in RCEM (2016) guidelines, by Association of Chief Police Officer<sup>8</sup> (ACPO, 2012) guidelines, Independent Police Complaints Commission (IPCC) reports (Hannan *et al.* 2010), the Faculty of Forensic and Legal Medicine (FFLM, 2010), and British Medical Association guidelines (BMA, 2009). It appears to represent the creation of what Fairclough (1992: 190-194) terms a ‘lexical item.’ Individuals affected by this phenomenon are recognised as constituting a ‘medical emergency’ and thus considered in

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<sup>8</sup> Replaced by the National Police Chiefs’ Council (NPCC) in April 2015.

urgent need of medical attention (Aiken *et al.* 2011). It predominantly affects men (Menaker *et al.* 2011) and typically those in their mid-thirties (RCEM, 2016).

The literature concurs that in crisis situations ED should be dealt with using a multi-agency approach that could include police, medical services and mental health teams. Furthermore, that frontline staff in these organisations should receive training in identifying and dealing with individuals who present symptoms of the phenomenon (Hall *et al.* 2013, Storey, 2012, Vilke *et al.* 2012, Aiken *et al.* 2011, NIJ 2011, IAP 2010). Individuals exhibiting characteristics of ED are viewed as requiring medical attention (Menaker *et al.* 2011, Marsh *et al.* 2009). Similarly, when called to attend to such individuals, the consensus is that public services should focus on de-escalation tactics rather than using force to subdue the individual (Reveruzzi and Pilling 2016, Cummins and Edmonson 2016, RCEM, 2016).

### ***Data and methods***

The twelve narrative verdicts used as data for this paper are drawn from a larger dataset of sixty-eight narrative verdicts used to construct a research monograph on the issue of DAPC<sup>9</sup>. They represent the views of juries in these cases and consequently provide some insight into how evidence is used by juries to make sense of complex, multi-causal cases of DAPC. Whilst it has been established that ED is a contested phenomenon, that does not necessarily mean it might not be a useful term in understanding aspects of causality in cases of DAPC, or in relation to preventing further deaths as a result. The data is qualitative, as it represents the views of jury members deliberating on each case. Consequently, the data is rich in detail, but limited to some extent in terms of generalisability due to the relatively small sample. Because of limited research on both DAPC and police involvement in cases of ED in the UK, it is not possible to assert how representative the sample is, as there is no definitive count of how many people presenting signs of ED died after police contact during this period (see Baker, 2016c for examples of difficulties in trying to research the issue of DAPC). Future research on this issue might consider IPCC investigation reports into the cases examined in this paper, as correlating the two sets of data may shed further light on some of the issues raised here.

The data for this paper was subjected to framework analysis (Ritchie and Spencer, 1994). First, the researcher became familiar with the corpus of data in order to gain an overview of the nature of its

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<sup>9</sup> Baker (2016a)

contents. Secondly, familiarisation enabled a thematic framework to be constructed using matrices. Thirdly, a process of indexing took place, to break the matrices down in terms of case numbers and key issues or terms. Fourthly, charting enabled indexing to be used to make associations within and between issues and terms. For example, in the research project that was undertaken, ED could be linked to specific terms identified by coronial juries, such as police training and/or communication. Finally, charting led to a process of mapping and interpretation. Maps emerged in the form of typologies such as particular conditions like substance misuse, or the relationship between restraint and mental health in cases of DAPC involving ED.

## **Discussion**

All twelve cases in the dataset were male and aged between 25 and 55 years of age, which largely concurs with the literature on this issue (RCEM, 2016, Menaker *et al.* 2011). All cases involved some combination of symptoms as previously identified by the literature earlier in this paper. Ten out of twelve cases involved restraint by police, eight cases involved substance misuse, half of the deaths involved individuals from BME communities. According to the IPCC (2016: 66) 29% of people who die after the use of police force are from BME communities. In this sense, the sample appears to confirm much of what the literature states about ED and the use of force. In the ten cases where restraint is identified as a factor in the death, three occur in healthcare settings, for example:

**Case 68:** *Question ‘Was the use of force by the police used to restrain [the deceased] in the treatment cubicle at the Accident & Emergency Department reasonable (that is, no more than necessary) in all the circumstances?’*  
*Answer: ‘No’.*

In eight of ten cases where restraint is noted, it is acknowledged as being either ‘lawful’ or ‘necessary’, or both, possibly highlighting the jury belief that ED imbues individuals with enhanced strength and that this necessitates the use of force by police to subdue them. It is notable that there are no cases in the dataset where a Taser has been used by police on the deceased. This is in sharp distinction to the literature from Canada and the US where Taser use is frequently identified in cases of DAPC when ED is determined to be present (see, for example Wozniak, 2016, Razack 2015, Storey, 2012, Brodeur 2010, Wetli, 2006).

A consistent theme in the literature is that while restraint might be necessary in such cases, it should wherever possible be avoided in favour of de-escalation techniques and containment until medical

teams can attend (FFLM, 2010, Kutcher *et al.* 2009, Paquette, 2003). However, there is a consistent thread in the literature on ED that restraint might not be the key issue in deaths where the phenomenon known as excited delirium is identified (Kutcher *et al.* 2009, Marsh *et al.* 2009, Wetli, 2006), for example:

**Case 46:** *'[The deceased] died from non dependant [sic] abuse of cocaine triggering an episode of excited delirium (which had not been fully appreciated), further aggravated by restraint.'*

Kutcher *et al.* (2009) and the UK Forum for Preventing Deaths in Custody (Aiken *et al.* 2011) agree that there should be a national monitoring system for the use of restraint in order to be able to analyse patterns and trends in cases of DAPC, at the time of writing there is no sign that this might occur.

In six out of twelve cases in the dataset juries note that police attending the scene were not aware of ED and could therefore not identify it. Whilst training and protocols exist for police in identifying ED (see, for example ACPO 2012, IAP 2010, FFLM 2010), juries appear to note that such training is not always followed in practice. Thus juries use policy documents in order to benchmark police actions or omissions in cases of DAPC (Baker 2016a). Clearly an inability to recognise a syndrome, or constellation of symptoms mean that police cannot follow guidelines when responding to such an incident. For example, the following comment:

**Case 25:** *'The police did not recognise the Classic Symptoms of excited delirium, as detailed in Centrex Documentation.'*<sup>10</sup>

In five cases police training is identified by coronial juries as being related to the death of the individual with ED either in relation to police but also to medical staff for example:

**Case 53:** *'Ineffective force staff training, failure to follow force procedures, failure to perform a timely medical assessment leading to a delayed call for assistance...may also have contributed to the death.'*

Thus ED is identified by juries as being either 'not recognised' or 'not appreciated' by officers attending an incident, echoing the observations above with regards to a failure to identify ED. Literature on other cases of DAPC has identified that officers have not always adhered to guidance or protocol despite having received the requisite training (Baker 2016a, Casale *et al.* 2013, Coles and Shaw 2012).

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<sup>10</sup> Centrex documentation was produced by the National Centre for Policing Excellence. This was the precursor to the National Police Improvement Agency (NPIA) in disseminating policy and practice to police in England and Wales. The NPIA was replaced by the College of Policing (CP) in 2013.



It should not necessarily be a surprise that juries therefore note police failure to adhere to training or protocols in this regard. It may be that a qualification recording a lack of knowledge in some way legitimises the use of restraint. The issue of 'medical emergency' is underlined in three cases, for example:

**Case 33:** *'There was an inability to recognise that [the deceased] was suffering from excited delirium, which is a medical emergency.'*

Juries chose to highlight failures of communication in five cases between police at the scene, as illustrated by the following statement:

**Case 66:** *'The only communication amongst the police officers were the words "break his arm".'*

Juries are also critical of the lack of communication between police and medical teams, for example:

**Case 32:** *Question 'Were adequate instructions give to police staff by the doctor in respect of the care and observations of [the deceased] both before and after an ambulance was called?' Answer 'No, the instructions were insufficiently clear.'*

Multi-agency working when responding to medical emergencies is key to managing complex cases, and thus communication is paramount between agencies when it comes to the prevention of death (Baker 2016a, Vilke *et al.* 2012). If de-escalating the situation is held to be central to preserving life in cases of ED (see, for example RCEM, 2016, Paquette, 2003) then communication is fundamentally important in establishing how de-escalation is to be managed in crisis situations.

### ***How useful is ED as a term?***

Whilst it is evident that the medical and scientific community cannot agree on whether ED is a medical condition, it seems clear that there is agreement that there is some type of syndrome that encapsulates a combination of factors. Thus there are numerous terms for ED in addition to a potential 'constellation of symptoms' (Hall *et al.* 2013, Storey, 2012, Vilke *et al.* 2012, NIJ 2011). This appears to echo the research of Langer *et al.* (2011: 150) who noted that the medico-scientific discourse that existed in inquests tended to aim: 'to separate human states into distinct illnesses that were due to well-defined causes.'

The difficulty in establishing causes of death in cases of DAPC has been previously noted. One thread of agreement in the literature on deaths after ED is that a single factor can seldom be attributed to

such deaths, underscoring the complexity of these cases. Highlighting particular conditions may, at least partially, enable a case to be explained primarily on the basis of that condition. If the physical or medical characteristics of the deceased can be identified as being causal in their death, then to some degree this may deflect attention from the actions or omissions of organisations involved (see, for example Baker, 2016a, Razack, 2015, Anaïs, 2014). This supports Hallam *et al.*'s (1999: 98) assertion that in the case of sudden death, it is unsurprising that a coroner's narrative: 'makes the death possible, indeed inevitable, for that person, in that place and at that time.'

If these characteristics can be ascribed with a degree of scientific or medical veracity, then they may be seen to be persuasive in explaining the cause of death. Research by Daftary-Kapur *et al.* (2010) and Spottswood (2013) asserts that juries tend to valorise medical and scientific evidence as objective truths. Having said that, Wozniak (2016: 199) notes that ED is a 'controversial medical explanation offered for a range of in-custody deaths', and that elements of the scientific and medical community are deeply sceptical about the existence of ED. This scepticism is echoed by Canadian authors writing about ED from the perspective of the police use of force (see, for example Razack, 2015, Anaïs, 2014, Brodeur, 2010). The US law-enforcement perspective, as stated by the NIJ (2011: 3) is more equivocal: 'It is important to point out that the fact that the AMA and APA having no official position regarding ExDS is not the same as officially stating that it does not exist.'

The medicalisation of an issue is a precondition to it being accepted in mainstream terminology and also being 'treated'; something Wozniak (2016: 200) terms the 'sickness as deviance model.' The fact that there is little agreement on what ED should be called, or what its symptoms are, or whether it is recognised by medical or psychiatric bodies should raise critical questions as to how relevant its use as a classificatory tool by coronial juries is in cases of DAPC. Writing on behalf of the UK Independent Advisory Panel on Deaths in Custody (IAP), Aiken *et al.* (2009: 53) suggest that: "'Sudden death in restraint syndrome" should be used to describe inquest verdicts rather than any euphemism in order to enhance clarity as this is a class of death we don't fully understand and is multifactorial.' The use of conditions as an explanatory tool by discourses of health and criminal justice has been noted previously by Dyson and Boswell (2006) in relation to sickle-cell anaemia as a way of explaining custody deaths of BME individuals. They believe the use of medical 'conditions' corresponds with a strand of 'reductionist genetics' in these discourses (Dyson and Boswell, 2006: 14). Similarly, Anaïs (2014) and Storey (2012) note 'Sudden Infant Death Syndrome' was at one time considered to be an objective cause of death but is now viewed with scepticism by both medical and legal professions.

Conversely, it must be recognised that if the advice much of the literature on ED is adopted by emergency services, and the phenomenon is treated as a medical emergency where de-escalation techniques and containment are used prior to medical intervention, then it might be that the number of deaths in ED cases could be reduced. The NIJ (in the US), and IAP (in the UK) concur with the assertion of Aiken *et al.* (2009: 56) that ‘the management of ED is more important than aetiology.’ Knowledge accrued through multi-agency experiences with ED has been adopted by the College of Policing (2017) in England and Wales in their guidelines on Authorised Professional Practice. This demonstrates that police training and guidelines have begun to shift on the issue of ED.

Police in the US, Australia and the UK have begun to engage in different methods to deal with mental health issues. Typically this occurs by combining police units with mental health professionals and/or paramedics to respond to emergency calls that highlight the possibility of mental health being an aspect of the emergency. In the US these units are termed ‘Crisis Intervention Teams’ (CITs) (Arey *et al.* 2016, Bonfire *et al.* 2014, Steadman *et al.* 2000); similarly, Critical Incident Response Teams (CIRTs) are used in Australia by Victoria police (see for example Cross, 2014, Chappell and O’Brien, 2014, Compton *et al.* 2008). In the UK, police in nine different forces have operated a Mental Health Triage pilot since 2013-14 (Reveruzzi and Pilling, 2016). Early indications from the evaluation of these pilots suggest that multi-agency working becomes more effective, communication between emergency services improves, and the number of individuals detained by police under s136 of the Mental Health 1983 decreases (Cummins and Edmonson, 2016, Reveruzzi and Pilling, 2016). A more holistic understanding of the individual’s mental health needs in a crisis situation appears to be enabled by the diverse skill sets that each emergency service brings. It seems possible that these developments might be transferrable to the way emergency services manage cases of ED.

## **Conclusion**

It has been established that cases of DAPC can be highly contentious and illustrative of the perceived excessive use of force against marginalised members of society. ED has apparently become one way of explaining how these deaths occur, but it too is highly contentious. There is a good deal of societal scepticism about both phenomena in addition to professional scepticism about the existence of ED as a ‘condition’. ED is marked by definitional ambiguity, uncertain aetiology, and a very broad palette of possible symptoms. Whilst it is not recognised by a number of medical bodies, it clearly

exists as a 'lexical item' in policies and guidelines issued to emergency services in England and Wales, and as a cause of death in narrative verdicts returned by coroners' juries in cases of DAPC.

The dataset used in this paper identifies the importance of multi-agency working in crisis situations when citizens are at risk of death. It highlights the importance of identifying factors specific to individuals in critical incidents and dealing with them appropriately. This requires multi-agency cooperation, better communication and more focus on de-escalating crisis situations. It suggests it is preferable to approach individuals in critical situations as though they are experiencing a medical emergency rather than restraining them due to a perceived need to enforce control. Whilst acknowledging the reservations that exist over ED, however, it does appear to be manifest as a constellation of symptoms and could thus be a useful tool in helping police identify individuals in crisis situations. The increasing use of CITs, CIRTs and Mental Health Triage schemes, and the use of multi-agency emergency responses seems to suggest that de-escalation is key to reducing incidents of harm to citizens; and this appears to fit with the approach suggested in the literature on ED. As a term that exists to record causes of death after police contact, ED represents one of a number of causes of death recorded by juries in the coronial system in contestable cases of DAPC. But as a term that might help police identify individuals in crisis situations, ED might prove helpful in reducing the number of deaths after police contact.

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